Multiparty Consent for the Release of Confidential Information

(NAME OF CONSUMER) _____ (Record #) _____ (Date of Birth) _____ (Social Security Number) _____

The purpose of this form is to allow me choice in how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to cancel this consent. This request will go to the facility's Medical Record or Health Information Department for processing. I also understand that I can ask a staff member to assist me with this process. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate and exchange information needed to coordinate and continue care, treatment and services. If I check no, I do not want the information exchanged with that provider.

Yes No

☐ ☐ Any Department of Mental Health and Substance Abuse Services operated facility including:

Ok County Crisis Intervention Center	Northwest Center for Behavioral Health
Griffin Memorial Hospital	Tulsa Center for Behavioral Health
Central Ok Community Mental Health Center	Jim Taliaferro Community Mental Health Center
Bill Willis Community Mental Health Center	Carl Albert Community Mental Health Center

Other Providers

Yes No

☐ ☐ HOPE Community Services
☐ ☐ North Care Center
☐ ☐ Associated Centers for Therapy, Inc.
☐ ☐ Grand Lake Mental Health Center, Inc.
☐ ☐ CREOKS Mental Health Services, Inc.
☐ ☐ Other _____

Yes No

☐ ☐ Red Rock Behavioral Health Services, Inc.
☐ ☐ Mental Health & Sub. Abuse Center of Southern Oklahoma, Inc.
☐ ☐ Edwin Fair Community Mental Health Center, Inc.
☐ ☐ Family & Children Services Mental Health Care, Inc.
☐ ☐ Green Country Behavioral Health Services, Inc.

Yes No	Yes No	Yes No
☐ ☐ Demographic Information	☐ ☐ Treatment Plan(s)	☐ ☐ Admit & discharge dates
☐ ☐ Assessments	☐ ☐ Physical Exam	☐ ☐ Discharge/Aftercare Plan
☐ ☐ Medications	☐ ☐ Lab/X-Ray Reports	☐ ☐ Release/Discharge Summary
		☐ ☐ Housing Information

Other -List specific document(s) or information:

_____

Date, Event, or Condition when Consent Expires: _____

In the event no date, event, or condition is specified for expiration, this consent expires one year from the date of signing.

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release.

I understand that the information and records disclosed pursuant to this consent may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by the regulations. State and Federal regulations prohibit any further disclosure of such information and records without my specific written consent unless otherwise permitted by such regulation.

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

_____ / _____ _____ / _____

Signature of consumer | Date | Witness (Optional) | Date

_____ / _____ _____

Signature of legal guardian when required | Date | Relationship to consumer